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FILED OCT 15 1945
Registration District No. **127**

Primary Registration District No. **9040**

Registrar's No. **124**

1. PLACE OF DEATH:

(a) County Livingston
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Chillicothe Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 69 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston
(c) City or town Mooreville
(If outside city or town limits, write "RURAL")
(d) Street No. General Delivery
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME GEORGE BARCLAY McMILLEN

3. (b) If veteran, name war No 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Maude McMillen 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased May 4th. 1876
(Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days 9 If less than one day hr. _____ min. _____

9. Birthplace Utica, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

12. Name John McMillen

13. Birthplace Bracken County, Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Susannah M. Stone

15. Birthplace Utica, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant John A. McMillen

(b) Address Mooreville, Missouri - 19-

17. (a) Burial (b) Date thereof 9-17-'45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Utica, Missouri.

18. (a) Signature of funeral director: Norman Funeral Home

(b) Address Chillicothe, Missouri.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 15th.
year 1945 hour 2:30 minute A. M.

21. I hereby certify that I attended the deceased from Oct. 20
1943, to Sept. 15, 1945

that I last saw him alive on Sept. 14, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Sarcoma of spine
Duration 2 1/2 yrs

Due to _____
Due to _____

Other conditions metastasis to neck & nose
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 559

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) _____
While at work? _____ (c) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address: [Signature] Date signed 9/14/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 4 1947

RECEIVED
District Health Officer No. 11,
District File Number
Date Filed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Frank. L. Smiley

Registered Apprentice No.

working under my personal supervision.

Signed

Frank L. Smiley

Licensed Embalmer No. 446

P. O. Address. Wheeling W.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 197

Primary Registration District No. 3040

Registrar's No. 124

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 69 years
years, months or days)

3. (a) PRINT FULL NAME George B. McMillen

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race W. 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 69 Months 4 Days 9 If less than one day hr. _____ min. _____

9. Birthplace (City, town, or county) _____ (State or foreign country) Mo

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Sept 17, 1945 Frances B. Neill
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day _____ year 1945 (hour) _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

30928